

TRICARE Prior Authorization Request Form for
mepolizumab injection (**Nucala**)



6480

To be completed and signed by the prescriber.



Clinical Documentation is required for a determination to be made.

Please fax completed form back to: (207) 828-7816

Prior authorization approves for up to 300mg for eosinophilic granulomatosis with polyangiitis (EGPA) and Hypereosinophilic Syndrome (HES).

Initial approvals expire after twelve months, renewal approvals are indefinite. For renewal of therapy an initial Tricare prior authorization approval is required.

Step 1 Please complete patient and physician information (please print):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for Nucala.</i>	<input type="checkbox"/> Yes (subject to verification) proceed to question 2	<input type="checkbox"/> No Proceed to question 6
2. What is the patient's diagnosis?	<input type="checkbox"/> severe persistent eosinophilic asthma - Proceed to question 3 <input type="checkbox"/> eosinophilic granulomatosis with polyangiitis (EGPA) - Proceed to question 4 <input type="checkbox"/> Hypereosinophilic Syndrome (HES) - Proceed to question 4 <input type="checkbox"/> chronic rhinosinusitis with nasal polyps (CRSwNP) - Proceed to question 5 <input type="checkbox"/> Other indication or diagnosis- STOP- Coverage not approved	
3. Has the patient had a positive response to therapy defined as a decrease in asthma exacerbations, improvements in forced expiratory volume in one second (FEV1) or decrease in oral corticosteroid use?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
4. Has the patient's disease severity improved and stabilized to warrant continued therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
5. Is there evidence of effectiveness as documented by decrease in nasal polyps score or nasal congestion score?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
6. Is the patient currently receiving another immunobiologic (for example, benralizumab [Fasenra], dupilumab [Dupixent] or omalizumab [Xolair])?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 7

TRICARE Prior Authorization Request Form for
mepolizumab injection (**Nucala**)

7. What is the patient's diagnosis?	<input type="checkbox"/> severe persistent eosinophilic asthma - Proceed to question 8 <input type="checkbox"/> eosinophilic granulomatosis with polyangiitis (EGPA) - Proceed to question 12 <input type="checkbox"/> Hypereosinophilic Syndrome (HES) - Proceed to question 14 <input type="checkbox"/> chronic rhinosinusitis with nasal polyps (CRSwNP) - Proceed to question 17 <input type="checkbox"/> Other indication or diagnosis- STOP- Coverage not approved
8. Is the requested medication being prescribed by an allergist, immunologist, or pulmonologist?	<input type="checkbox"/> Yes Proceed to question 9 <input type="checkbox"/> No STOP Coverage not approved
9. Does the patient have an eosinophilic phenotype asthma as defined as either: <ul style="list-style-type: none"> • blood eosinophil count of GREATER than or EQUAL to 150 cells/mcL within the past month while on oral corticosteroids OR • blood eosinophil count of GREATER than or EQUAL to 300 cells/mcL within the past year? 	<input type="checkbox"/> Yes Proceed to question 10 <input type="checkbox"/> No STOP Coverage not approved
10. Has the patient's asthma been uncontrolled despite adherence to optimized medication therapy regimen? <i>Uncontrolled asthma is defined as one of the following: hospitalization for asthma in the past year, OR requiring a course of oral corticosteroids twice in the past year, OR requiring daily high-dose inhaled corticosteroid (ICS) with inability to taper off the ICS.</i>	<input type="checkbox"/> Yes Proceed to question 11 <input type="checkbox"/> No STOP Coverage not approved
11. Has the patient tried and failed an adequate course (3 months) of at least TWO of the following while using a high-dose inhaled corticosteroid: <ul style="list-style-type: none"> • Inhaled long-acting beta agonist (LABA) (for example, Serevent, Striverdi), • long-acting muscarinic antagonist (LAMA) (for example, Spiriva, Incruse), • leukotriene receptor antagonist (for example, Singulair, Accolate, Zyflo)? 	<input type="checkbox"/> Yes Sign and date below <input type="checkbox"/> No STOP Coverage not approved
12. Is the patient GREATER THAN or EQUAL TO 18 years of age?	<input type="checkbox"/> Yes Proceed to question 13 <input type="checkbox"/> No STOP Coverage not approved
13. Is the requested medication being prescribed an allergist, immunologist, pulmonologist, rheumatologist, or hematologist?	<input type="checkbox"/> Yes Sign and date below <input type="checkbox"/> No STOP Coverage not approved
14. Has the patient had blood eosinophil count of GREATER than 1,000 cells/mcL in the past year?	<input type="checkbox"/> Yes Proceed to question 15 <input type="checkbox"/> No STOP Coverage not approved
15. Is the requested medication being prescribed an allergist, immunologist, pulmonologist, rheumatologist, or hematologist?	<input type="checkbox"/> Yes Proceed to question 16 <input type="checkbox"/> No STOP Coverage not approved
16. Is the patient GREATER THAN or EQUAL TO 12 years of age?	<input type="checkbox"/> Yes Sign and date below <input type="checkbox"/> No STOP Coverage not approved
17. Is the requested medication being prescribed as add-on maintenance therapy due to patient having inadequate response to nasal corticosteroid?	<input type="checkbox"/> Yes Sign and date below <input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date

[18 November 2022]

Please attach office notes (clinical documentation)